Supreme Court, U.S.
FILED

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No.

IN THE

Supreme Court of the United States

EDNA L. WILLIAMS,

Petitioner

v.

BENICORP INSURANCE COMPANY,

Respondent

On Petition for Writ of Certiorari
To The United States Court of Appeals
For the Eleventh Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether ERISA preempts a state law claim against an insurer for its negligence in failing to notify its insured that it denied his claim for a lung transplant benefit, thus preventing the insured from seeking health benefits outside the ERISA plan from non-ERISA sources.

PARTIES TO THE PROCEEDINGS

Edna L. Williams is the petitioner.
Benicorp Insurance Company is the sole respondent.

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PETITION FOR A WRIT OF CERTIORARI

The undersigned, on behalf of Edna L. Williams, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eleventh Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a) is unreported. The opinion of the district court (App., *infra*, 3a-13a) is also unreported.

JURISDICTION

The judgment of the court of appeals was entered on August 26, 2003. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTE INVOLVED

The pertinent provisions of the Employee Retirement Income Security Act (ERISA) are reprinted in an appendix

to this petition. App., *infra*, 14a-16a.

STATEMENT

This case presents the question whether ERISA preempts any state remedy for a case in which an insurer negligently fails to notify the insured that it is declining to provide coverage for a life-saving treatment in time for the insured to seek coverage from other, non-ERISA sources.

1. Plaintiff Edna Williams and her late husband James Williams were insured by a group health insurance policy issued to their Georgia employer by Defendant Benicorp. By October of 1999 Mr. Williams developed pulmonary fibrosis. Around October 13, 1999, Mr. Williams called Robin Clark, a Care Manager for Benicorp, and told her he had been recommended for a lung transplant in Alabama by his physicians. App., *infra*, 4a.

Ms. Clark called Barb Rouse, Vice President of Benicorp's Group Operations, who informed Clark that the insurance policy covered 'heart transplants' and 'heart and lung transplants' only. The specific provision provides:

> Category 2: Covered Expenses incurred for anyone of the following procedures will be covered up to a maximum lifetime benefit of $50,000[1] ... 1.) Human Heart transplants; 2.) Heart and Lung transplants; 3.) Liver transplants; 4.) Kidney transplants; and 5.) Bone marrow transplants. No benefit will be paid for any transplant/replacement procedure not specifically listed above.

After the phone call from Ms. Rouse, Ms. Clark called the transplant coordinator to advise the hospital there was no insurance coverage for the lung transplant. App., *infra*, 5a.

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[1] This monetary limit was removed in a rider to the policy.

Although Benicorp denied coverage for lung-only transplants, it never let Mr. Williams know of the denial so that he could either seek financing through state medicaid or make a formal demand. As far as the record reveals, he first learned of the denial of coverage from the hospital on November 9, almost a full month after Benicorp denied coverage. App., *infra*, 28a-29a.

On October 18, the Alabama hospital's social worker stated to Ms. Clark that she would begin efforts to refer Mr. Williams to Emory University in Georgia since there was no transplant coverage. App., *infra*, 27a. Ms. Clark did not follow up the transplant issue until she called Mr. Williams on October 29, at which time she was told by Mrs. Williams that she was still dealing with the Alabama hospital's transplant coordinator to get the transplant organized. App., *infra*, 27a. In a follow-up conversation with Mr. Williams on November 1, Ms. Clark learned that he was still waiting for testing to occur at the Birmingham Transplant Center. She still failed to tell him that Benicorp denied coverage for his transplant. App., *infra*, 27a-28a.

On November 5, 1999, Mr. Williams was admitted to the Houston Medical Center, where he stayed for the rest of his life. On November 8 (the next Monday), the hospital made inquiries to Benicorp concerning Mr. Williams's benefits. On November 9, Mrs. Williams called Ms. Clark, advising that she was told that there is no transplant benefit and wanting to know why. App., *infra*, 28a-29a. This is the earliest indication in the record that either of the Williamses had been informed by anyone that coverage for a transplant had been denied.

At this point, various efforts were made to get Benicorp to agree to cover a transplant or to issue a "decline letter" so that state medicaid coverage could be sought for the transplant. App., *infra*, 19a, ¶11. In Benicorp's first writing addressing the issue, a letter of November 16, Barb

Rouse of Benicorp stated that she had theretofore addressed only telephone inquiries about the scope of the transplant benefit, that it had not received a "formal predetermination of benefits for a lung transplant" nor "any specific medical documentation from his attending physicians," that the issue was a matter of contract interpretation, and that she would look into it and respond within a few days. App., *infra*, 29a-30a.

Meanwhile, Benicorp sought alternative financing through its reinsurance company. On November 18, 1999, Benicorp notified the hospital, and attempted to notify Plaintiff Edna Williams, that the reinsurance carrier decided to make a one-time exception to the policy and would cover Mr. Williams' transplant. Unfortunately, Mr. Williams passed away in the early morning hours of November 18, 1999 before the transplant process could begin. App., *infra*, 5a, 30a-31a.

2. Mrs. Williams sued Benicorp and her employer's insurance agent in state court, and the claim was removed to district court. As amended, and after dismissing a claim against her employer's insurance broker, the complaint stated two claims against Benicorp. The first claim was a state law wrongful death claim based on the negligence of Benicorp or its agents in failing to notify Mr. Williams of its October 13, 1999, decision not to provide a lung transplant benefit in time for Mr. Williams to seek other sources of funding for the life-saving transplant. App., *infra*, 20a, ¶¶17, 18. The second claim was that, under ERISA's provision granting "other appropriate equitable relief," Mrs. Williams was entitled to require Benicorp to disgorge the money it saved by improper conduct that delayed life-saving treatment until it was too late. App., *infra*, 23a-24a, ¶25.

Benicorp moved for summary judgment on both issues, and the motion was granted. App., *infra*, 3a-13a. As for the claim seeking relief under state law, the district court relied

heavily on this Court's decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), and concluded that the state law claims were completely preempted because 29 U.S.C. § 1132 of ERISA provides the exclusive remedy for claims involving the mishandling of a benefit request. App., *infra*, 8a, 12a, 13a. The district court may have also concluded that they were expressly preempted under 29 U.S.C. § 1144 because the state law principle "related to" an ERISA plan. App., *infra*, 9a-10a. The district court implicitly rejected Mrs. Williams's position that this sort of claim (a) is beyond the scope of the complete preemption doctrine because it is completely consistent with having no rights to a transplant under the contract, and instead involves Benicorp's negligent interference with Mr. Williams's obtaining non-ERISA benefits from non-ERISA sources, and (b) comes within the saving clause exception to express preemption. 29 U.S.C. § 1144(b)(2)(A).

As for the second claim seeking "other appropriate equitable relief" under 29 U.S.C. § 1132(a)(3), the district court held that (a) the remedy of disgorging money improperly saved was in reality "money damages" and not available under this provision, and (b) if it were a proper claim under ERISA, plaintiff had failed to exhaust her administrative remedies. App., *infra*, 11a-12a.

3. On appeal, the Eleventh Circuit held in a brief unpublished opinion that plaintiff's claims were foreclosed for the reasons stated in the district court's opinion. App., *infra*, 1a-2a.

REASONS FOR GRANTING THE PETITION

Preemption of state law claims under ERISA continues to cause inordinate difficulties for the lower courts, both in terms of formulating the standards that distinguish the sorts of claims that are preempted from those that are not, and in terms of applying those standards to the nuances of

factual situations. It has caused gross injustices that directly contradict Congress's stated intent in enacting ERISA and its expressed intent regarding the preemption of state laws. This Court has recently granted certiorari to consider these issues, and the present case should be considered for the same reasons.

Williams will first explain the nature of the Georgia common law rule on which she relies and show that this rule has the effect of regulating insurance, thereby avoiding express preemption under the saving clause, 29 U.S.C. § 1144(b)(2)(A). Then Williams will focus on the complete preemption analysis.

1. a. Unless preempted by ERISA, Williams has a viable cause of action under Georgia law against Benicorp for its negligence in failing to inform Mr. Williams promptly of its decision to deny coverage. In a variety of contexts, Georgia common law imposes on insurers duties of good faith and ordinary care toward their insureds. *See e.g., Home Ins. Co. v. Sunrise Carpet Indus.*, 493 S.E.2d 641, 644 (Ga. App. 1997) (setting premiums); *Southern General Ins. Co. v. Holt*, 416 S.E.2d 274, 276 (Ga. 1992) (giving equal consideration to interests of insured in deciding whether to settle third-party liability claims). As applied to an insurer's decision to decline coverage for a claim under the policy, Georgia common law requires that the insurer inform the insured immediately that coverage has been denied so that the insured may protect his or her interests through other means.

> While [the insurer] had a right to investigate whether it had a duty to defend and provide coverage, it was obliged to inform [the insured] *immediately* that it intended to deny coverage if it learned of information indicating that no coverage existed under its policy.

Ponse v. Atlanta Cas. Co., 563 S.E.2d 499, 501-02 (Ga. App.

2002) (liability insurer liable for insured's default because it did not communicate denial of coverage). Under this rule, the insurer may be liable to the insured for damages caused by failure to notify of the denial, even if the insurer has an otherwise entirely valid defense. *Id.* (misrepresentations in the application for the policy). In the context of the present case, Georgia imposed a duty on Benicorp as an insurer doing business in the state to notify insureds like Mr. Williams of a denial of coverage so that he could take other steps to save his life. Benicorp could not simply ignore Mr. Williams, even if it had an absolute defense to liability under the policy.

b. Georgia's law differs from the tort of bad faith breach of contract that was addressed by this Court in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). That bad faith law applied tort sanctions for the bad faith breach of whatever contractual duties the parties agreed upon; it did not alter those contractual duties. *Id.*, at 50-51. The risks undertaken by the insurer did not increase because of the state's bad faith tort law. The insurer had no additional duty because of the bad faith tort law that it did not have under the contract. Therefore, the bad faith tort law did not affect the allocation of the risk between the parties; it simply increased the sanctions for those violations of contractual duty that were adjudged to occur in bad faith. Such tort claims are not available under Georgia law. *Hub Motor Co. v. Burdakin*, 386 S.E.2d 854, 855-56 (Ga. App. 1989). Although Georgia recognizes that a duty of good faith is an implicit term of contracts, the breach of this general duty is not a tort; it is at most a breach of the contract, and damages are limited to what the contract provides. *ServiceMaster Co. v. Martin*, 556 S.E.2d 517, 522 (Ga. App. 2001); *Wynn v. Arias*, 531 S.E.2d 126, 131 (Ga. App. 2000).

By contrast, the liability imposed by Georgia common

law rests in tort, not contract. *Alexander Underwriters General Agency, Inc. v. Lovett*, 357 S.E.2d 258, 265 (Ga. App. 1987). It flows from a recognition that an insurer is a professional in claims handling and that it has a financial stake that is, or may become, adverse to its insured. *Thomas v. Atlanta Cas. Co.*, 558 S.E.2d 432, 439 (Ga. App. 2002); *United States Fidelity & Guaranty Co. v. Evans*, 156 S.E.2d 809, 811 (Ga. App. 1967). Thus, following the pattern of law applicable to other professionals, insurers in dealing with insureds are held to the standard of "an ordinarily prudent insurer." *Cotton States Mut. Ins. Co. v. Brightman*, 580 S.E.2d 519, 521 (Ga. 2003). This duty is quite independent of whether the insurer breaches the contract.

2. This type of tort is saved from express preemption under 29 U.S.C. § 1144(a) by the "saving clause," which creates an exception for "any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A). In particular, it satisfies both prongs of the analysis recently adopted by this Court in *Ky. Ass'n of Health Plans, Inc. v. Miller*, 123 S.Ct. 1471, 1479 (2003).

a. This tort, as developed in Georgia case law, is specifically directed to the insurance industry. As shown just above, Georgia case law imposes duties on insurers to interact with their insureds in a variety of contexts under the standard of "an ordinarily prudent insurer." *Brightman, supra*, 580 S.E.2d at 521. Because Georgia law recognizes that the insurer is a professional in claims handling and must conform to the standard of an ordinarily prudent insurer, the common law duties are directed to the insurance industry alone. *See UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 370-72 (1999) (California common law notice-prejudice rule that was *mandatory* for insurers was a law that "regulates insurance" because it exceeded general state law that merely disfavored

forfeitures), *overruled on a different point by Miller*, *supra* at 1471.

b. This tort also "substantially affect[s] the risk pooling arrangement between the insurer and the insured." In *Miller*, *supra* at 1478-79 n. 3, this Court cited *UNUM Life*, as a clear example of a common law rule affecting risk pooling arrangements. This prong of the saving clause analysis "does *not* require that the state law actually spread risk," but it "requires only that the state law substantially *affect* the risk pooling arrangement between the insurer and insured." *Id.* The notice-prejudice common law rule in *UNUM Life* was upheld against preemption because it

> governs whether or not an insurance company must cover claims submitted late, which dictates to the insurance company the conditions under which it must pay for the risk that it has assumed. This *certainly* qualifies as a substantial effect on the risk pooling arrangement between the insurer and insured.

Miller, *supra* n.3 (emphasis added). For like reasons, the Georgia case law under *Ponse*, *supra*, affects the risk-pooling arrangement by transferring risks from the insured to the insurer. In contrast to the bad faith claims addressed in *Pilot Life* that simply provide additional remedies for the breach of pre-existing contract duties, Georgia law imposes a substantive *duty* to notify an insured so that the insured may protect himself outside the contract. Georgia's common law rule sets terms under which the insured's risk is transferred to the insurer. It therefore comes within the saving clause.

3 The doctrine of "complete preemption" holds that 29 U.S.C. § 1132 provides the exclusive remedy for enforcement of a plan participant's rights under ERISA, and this was the principal reason cited for the grant of summary judgment to Benicorp in this case. App., *infra*, 8a-

12a, 13a. The doctrine is rooted in this Court's discussion in *Pilot Life*. In that case, the found that Mississippi's tort of bad faith breach of contract was not a "regulation of insurance" and thus was not saved from preemption under § 1144(b)(2)(A), 481 U.S. at 44-51, a finding that would be fully dispositive of the case. The Court then proceeded to analyze the preemptive effect of 29 U.S.C. § 1132 and concluded that Congress intended for the statute to provide the exclusive remedy for violations of a plan participant's rights, citing (a) the drafter's extensive care in crafting the provisions of § 1132, and (b) the legislative history that this provision was conceived by some legislators as modeled after an exclusive remedy provision under the Labor Management Relations Act. *Pilot Life*, 481 U.S. at 51-56.

Since the 1987 decision in *Pilot Life*, however, practice has exposed numerous problems with an expansive treatment of the complete preemption doctrine. Objections have fallen into at least three categories: (a) uncertainty in formulating the standards for finding that a state law claim is completely preempted, and the difficulty in applying such standards; (b) the legal and moral problems caused by immunizing insurers from liability; and (c) the textual problem that treating § 1132 as an exclusive remedy conflicts with § 1144(b)(2)(A), which expressly saves regulation of insurance from the preemptive effect of the entire subchapter in which both sections appear.

a. Recent decisions have observed with frustration the uncertainty of the verbal standards for distinguishing the sorts of claims for which § 1132 should be the exclusive remedy and other claims which, though having some tenuous connection to an ERISA plan, are too remote to be preempted.

In *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 2003 U.S. App. LEXIS 20942 (3rd Cir. 2003), each of the judges wrote separately about the difficulties that complete

preemption jurisprudence has caused. Judge Rendell's opinion tracked the distinction in Third Circuit cases through three stages: (1) originally, claims going to the "quality" of the benefit were not preempted, but those going to the "quantity" of the benefit were preempted; (2) later, the distinction was cast in terms of claims arising out of "eligibility decisions," which were preempted, and those arising out of "treatment decisions," which were not; and (3) now, whether the claim could be brought under § 1132(a), in which case it is preempted, and otherwise not. *Id.*, *9-*15. Note 3 of her opinion observes that various circuits have applied different approaches to determining whether a claim is completely preempted by § 1132. *Id.*, *23, n.3. She reflects that determining the scope of preemption under § 1132 has "proven to be anything but an exact science" which has "taken on a life of its own, and not a very satisfying or productive life at that." *Id.*, *8-*9. Judge Becker's concurring opinion referred to the task of applying the standard as a "Serbonian bog," a quagmire, posing "extraordinary subtleties and complexities ... that cry out for clarification by the Congress, or, failing that, by the Supreme Court." *Id.*, *32, *51, *54.

In *Roark v. Humana, Inc.*, 307 F.3d 298 (5th Cir. 2002), *cert. granted sub nom. Aetna Health Inc. v. Davila*, (U.S. Nov. 3, 2003) (No. 02-1845), the Fifth Circuit surveyed this Court's holdings from *Pilot Life* through *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 359, 379 (2002), noting that *Pilot Life* contained some expansive language arguably supporting preemption of a tort claim based on an HMO's negligence in making a determination of "medical necessity," but that *Rush Prudential* substantially narrowed the scope of preemption in terms of whether the state law essentially duplicates a cause of action listed in § 1132. *Roark*, 307 F.3d at 310-11. In *Rush Prudential*, this Court explained the basis of *Pilot Life* in terms of a

Congressional intent to reject certain remedies for plan violations, which intent should not be subverted by allowing state law to provide the rejected remedies "at the ultimate step of plan enforcement." *Rush Prudential*, 536 U.S. at 378. Thus, the Court presented the complete preemption doctrine in terms of precluding alternative remedies, which would have the effect of precluding state law remedies that change or supplement the relief available under § 1132 to enforce the participant's rights under the plan, but not the effect of precluding state law claims that do not involve enforcing a right under the plan.

In *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995), the Seventh Circuit determined the bounds of the complete preemption doctrine by analogy to the LMRA and cases decided under it which were influential to this Court in *Pilot Life*. Examining those LMRA cases, the court observed that state law claims are not preempted if their resolution "does not require construing the agreement." *Rice*, 65 F.3d at 643, *citing Lingle v. Norge Div. of Magic Chef, Inc.*, 486 U.S. 399, 407 (1988), and *Livadas v. Bradshaw*, 512 U.S. 107, 124 (1994). It concluded that the test is whether the "state law claim cannot be resolved without an interpretation of the contract governed by federal law." *Rice*, 65 F.3d at 644.

The variety of tests for finding the boundaries of preemption under § 1132 is significant to Mrs. Williams and to many other plans and plan participants across the nation. Mrs. Williams's claim is that by its actions, Benicorp prevented Mr. Williams from taking actions outside the ERISA plan to save his life, while there was time to do so. Her claim would arise outside of the scope of preemption under some of these formulations because it does not require a favorable interpretation of the contract; it is completely compatible with a finding that Benicorp was justified initially in denying coverage for the transplant and

was merely negligent in failing to communicate the denial. Nor does this tort duplicate a claim available under § 1132(a); Benicorp's actions deprived Mr. Williams of the opportunity to get medicaid or other benefits *outside* the contract. On the other hand, some general language contained in *Pilot Life* or in lower court opinions relating to "eligibility decisions" or "quantity of benefit" could arguably preempt her claim. Indeed, the district court relied upon such language in *Pilot Life*, 481 U.S. at 56, for the proposition that ERISA provides the exclusive remedy for any claim that a plan administrator "mishandled a benefit request," App., *infra*, 13a, even if, as here, the plan participant is not seeking to enforce *any* term of the ERISA plan.

For the same reasons that this Court granted certiorari in *Roark*, *supra*, petitioner respectfully submits that the Court should grant certiorari in this case, or in the alternative, hold the resolution of this case pending the outcome of that case.

b. Numerous courts and commentators have observed that stripping insurers of responsibility for the consequences of their actions that endanger human life, a subject normally within the regulatory purview of the states, is legally and morally untenable – so much so as to raise doubts that Congress could have intended the result. The subject was extensively discussed in the concurring opinion of Judge Becker in *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 2003 U.S. App. LEXIS 20942, *31-*74 (3rd Cir. 2003). He summarized the problem thus:

> ... ERISA has evolved into a shield that insulates HMOs from liability for even the most egregious acts of dereliction committed against plan beneficiaries, a state of affairs that I view as directly contrary to the intent of Congress. Indeed, existing ERISA jurisprudence creates a

> monetary incentive for HMOs to mistreat those beneficiaries, who are often in the throes of medical crises and entirely unable to assert what meager rights they possess.

Id., *31-*32. Although the remedial provisions of § 1132 seem to provide adequate remedies at first glance,

> they in fact operate to leave participants almost completely at the mercy of HMOs. The first section, 502(a)(1)(B), by its plain language only allows plan participants to seek the benefits to which they are contractually entitled, even when those benefits have been denied in bad faith and despite the fact that the participants most in need of this section are often the ones least able to take advantage of it. A plan participant whose claim is denied by an HMO's utilization review board ... is often in the throes of a life-or-death medical crisis, hardly a feasible time to retain counsel and prosecute an injunctive lawsuit. The costs of such suits are likely to be immense, and ERISA provides for attorney fees, if at all, only after the action concludes. *See* § 502(g)(1). Even if a participant ultimately prevails against his insurer, it will frequently be the participant's estate that reaps the meager reward.

Id., *43-*44. In the absence of a remedial structure that provides an incentive for attorneys to represent clients on a contingent fee basis,

> participants in the midst of medical crises are completely at the mercy of HMOs unless they are fortunate enough to have the financial means to bring a suit for an injunction, a circumstance which is no doubt exceptional. Although it might seem a simple matter to seek

> an injunction compelling contractually-guaranteed coverage of a procedure, nothing is further from the truth where ... the contractual availability of coverage hinges on a highly fact-intensive determination of medical necessity involving accepted standards of care and tolerable levels of risk for the participant's malady. To the extent that participants are unable to seek an injunction compelling coverage, ERISA's remedial scheme is almost entirely illusory.

Id., *47-*48. Preemption also gives insurers strong incentives to let chronically ill participants die.

> Any rational HMO will recognize that if it acts in good faith, it will pay for far more procedures than if it acts otherwise, and punitive damages, which might otherwise guard against such profiteering, are no obstacle at all. Not only is there an incentive for an HMO to deny any particular claim, but to the extent that this practice becomes widespread, it creates a "race to the bottom" in which, all else being equal, the most profitable HMOs will be those that deny claims most frequently.

Id., *48-*49. The ultimate irony of preemption under § 1132 is that it flatly contradicts the expressed purpose of ERISA to "protect ... the interests of participants in employee benefit plans and their beneficiaries ... by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b). As the preemption doctrine has played out in cases such as the present one, it "protects" their interests by stripping them of their protections under state law and leaving them to the good graces of those who, in some cases, including this one, would benefit economically if the employee dies.

> The H.M.O.s know the economics as well as anybody, and better than most.... Deny a treatment at the initial or emergency stage and the patient may go away, or seek another or more expensive policy. Or die - thus conclusively tidying up the books on the right side of the ledger.

Christine Lockhart, *The Safest Care is to Deny Care: Implications of Corporate Health Insurance, Inc. v. Texas Department of Insurance on HMO Liability in Texas*, 41 S. Tex. L. Rev. 621, 631 (2000).

> To state the problem bluntly, there is a potentially lethal economic flaw in the HMO concept. The flaw is that the final say on whether a person gets life-extending treatment is consigned to an entity that can have a strong economic interest in seeing the subscriber dead, as soon as possible. The shorter the lives of the chronically ill, the less the HMO will have to pay for their care. No one would think it fair to hold trials before judges who have personal financial stakes in the outcomes. Yet, this is precisely the way that the HMO concept is structured. That is, arguably at least, a very serious flaw.

John A. Humbach, *Criminal Prosecution for HMO Treatment Denial*, 11 Health Matrix 147, 161 (2001).

The foregoing considerations suggest that the Court should reconsider whether the text of § 1132 shows that Congress actually intended consequences that so contradict the expressed purpose of the statute and natural justice.

c. Likewise problematic is the direct textual conflict between preemption under § 1132 and the saving clause of § 1144(b)(2)(A), which states that "nothing in this subchapter shall be construed to exempt or relieve any

person from any law of any State which regulates insurance." Because § 1132 occurs in the same subchapter, the saving clause on its face prohibits a construction of § 1132 that would exempt insurers from *any* state law that regulates insurance, logically including those that create remedies for plan violations, the text of the saving clause conflicts with an expansive view of the complete preemption doctrine in cases involving state law claims against insurers.

In *Pilot Life*, this Court was not called upon to reconcile the conflict because it found that the tort of bad faith did not regulate insurance. On two later occasions, this Court has recognized the conflict without formally resolving it. In *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358 n. 7 (1999), the Court observed that one of the major reasons cited in *Pilot Life* for finding complete preemption under § 1132, namely that ERISA was patterned after the LMRA, was called into question because the LMRA lacks any text comparable to the saving clause. Nevertheless, the Court did not address the conflict because the claim before the Court was for benefits under ERISA rather than a state law claim. Most recently, in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 359, 377-80 (2002), the Court observed that it has not yet been required to resolve the conflict, that it had anticipated a resolution in *Pilot Life*, but that in any case, the complete preemption doctrine would not be conceived so expansively as to preempt state laws requiring independent reviews of disputes about plan benefits and requiring HMOs to pay for services deemed medically necessary by the independent reviewer. The Court did not resolve the conflict; it merely held that under any valid interpretation of the complete preemption doctrine, the independent review statute would not be preempted.

The Eleventh Circuit, like almost all other courts, has held that until this Court reconsiders *Pilot Life*, it would

continue to follow *Pilot Life*'s apparent holding that the inferred Congressional intent to require complete preemption trumps its expressed intent not to displace state laws regulating insurance. *Walker v. Southern Co. Services, Inc.*, 279 F.3d 1289, 1293-94 (11th Cir. 2002); *Gilbert v. Alta Health & Life Ins. Co.*, 276 F.3d 1292, 1299-1300 (11th Cir. 2001). This Court should grant the writ to resolve the issue. In particular, the Court should resolve it in a way that is consistent with the relatively early recognition that Congress intended to allow states to regulate insured ERISA plans indirectly, including regulations that require certain benefits (liabilities) to be provided, even if such liabilities contradict the expressed terms of the policies, and even if the regulation caused some "disuniformities" in the handling of claims in different states. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985).

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted. In the alternative, the Court should hold this case pending the resolution of *Aetna Health Inc. v. Davila*, No. 02-1845 (cert. granted Nov. 3, 2003).

Respectfully submitted.

Charles M. Cork, III

Appendix A

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 03-12247

EDNA L. WILLIAMS, Plaintiff-Appellant

v.

BENICORP INSURANCE COMPANY, JOHN DOE,
JOHN DOE CORPORATION, Defendants-Appellees,
and BOSWORTH & ASSOCIATES, INC., Defendant

Filed: August 26, 2003

Before TJOFLAT, DUBINA and MARCUS, Circuit Judges.

PER CURIAM:

The district court granted appellee summary judgment in this case in which appellant seeks money damages under Georgia tort law on the ground that appellee failed to notify her decedent in a timely manner that it would not pay for the decedent's lung transplant operation. Appellant also contends that appellee is liable for such damages under theories of estoppel and unjust enrichment.

The district court, in its comprehensive order of March 27, 2003 granting appellee's motion for summary judgment, held that ERISA preempts appellant's claims and does not

provide for the damages remedy appellant seeks. For the reasons stated in the district court's order, we agree that appellant's claims are foreclosed.

AFFIRMED.

Appendix B

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

No. 5:01-CV-508-1(WDO)

EDNA L. WILLIAMS, Plaintiff

v.

BENICORP INSURANCE COMPANY, Defendant

Filed: January 15, 2003

ORDER

Plaintiff brought suit against Defendant Benicorp for failure to provide benefits for a lung transplant under her late husband's health insurance policy. Plaintiff also asserted claims against Bosworth & Associates, the insurance broker, for its alleged failure to provide the documentation required by Benicorp to approve the insurance benefits. Plaintiff voluntarily dismissed Bosworth without prejudice. After conceding that many of her state law claims have no merit, Plaintiff's only remaining claim is based on Benicorp's alleged failure to timely deny the request for benefits. The matter is now before the Court on Defendant Benicorp's Motion for Summary Judgment.

I. Factual and Procedural Background

Below are the undisputed facts upon which the factual and legal findings in this order are based.[1] At all times relevant to Plaintiff's claims, Plaintiff Edna Williams and her late husband James F. Williams were insured by a group health insurance policy sponsored by their employer Judd Publishing and issued by Defendant Benicorp.[2] By October of 1999 Mr. Williams had developed pulmonary fibrosis. On or about October 13, 1999, Mr. Williams called Robin Clark, a Care Manager for Benicorp, and told her he had been recommended for a lung transplant by his physicians at the Kirklin Clinic at the University of Alabama in Birmingham. Ms. Clark called Barb Rouse, Vice President of Benicorp's Group Operations, who informed Clark that the insurance policy under which Mr. Williams was insured (the "Plan") covered 'heart transplants' and 'heart and lung transplants' only.[3] The specific provision provides

> Category 2: Covered Expenses incurred for anyone of the following procedures will be covered up to a maximum lifetime benefit of $50,000 ... 1.) Human Heart transplants; 2.) Heart and Lung transplants; 3.) Liver transplants; 4.) Kidney transplants; and 5.) Bone marrow transplants. No benefit will be paid for any transplant/replacement procedure not specifically listed above.[4]

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[1] Because Defendant filed a motion to strike certain portions of Plaintiff's statement of facts, the facts relied upon in this order are limited to the undisputed facts presented by both parties and established by the record.

[2] R. at 40, Ex. 2, p. 8, 15 (Edwin Judd, Sr. Dep.).

[3] R. at 40, Ex. 7, p. 0225.

[4] R. at 43, Ex. A, p. 39.

After the phone call from Ms. Rouse, Ms. Clark contacted Kirklin's Transplant Coordinator to advise the hospital there was no insurance coverage for the lung transplant. Although the Defendant maintained the Plan did not cover the transplant, it sought alternative financing through its reinsurance company. On November 18, 1999, Defendant notified the hospital, and attempted to notify Plaintiff Edna Williams, that the reinsurance carrier decided to make a one-time exception to the policy and would cover Mr. Williams' transplant. An employee of Benicorp sent a fax regarding this decision to the Judd Publishing office, a letter was sent to Ms. Williams' home and a representative of the insurance company called the hospital to notify the Williamses of the availability of coverage for the transplant.[5] Unfortunately, Mr. Williams passed away in the early morning hours of November 18, 1999 before the transplant process could begin.

Plaintiff brought the instant suit against Defendant Benicorp based on its denial of medical benefits for the transplant. Defendant contends it is entitled to summary judgment on Plaintiff's claims because (1) they are preempted by ERISA; (2) Plaintiff failed to exhaust ERISA administrative remedies prior to filing suit in this court[6]; (3) neither Plaintiff Edna Williams nor the late Mr. James F. Williams ever filed a claim requesting coverage for the lung transplant; and (4) Benicorp never received the predetermination of benefits from Mr. Williams' attending physicians as required by the Plan.[7] Although Plaintiff has argued that her claims are not preempted by ERISA, she

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[5] R. at 40, Ex. 6, 7; R. at 42, p. 33 (Edwin Judd Dep.).

[6] R. at 43, Ex. A, p. 25 "CLAIM REVIEW PROCEDURE."

[7] R. at 40, Ex. 5; R. at 43, Ex. A, p. 24 "PAYMENT OF CLAIMS," p. 48 "TREATMENT CERTIFICATION PROGRAM."

now concedes that the one remaining claim is in fact covered by ERISA. However, Plaintiff contends Defendant should be equitably estopped from asserting ERISA's applicability because of certain language in the Plan.[8] Plaintiff contends that Defendant Benicorp included language in the Plan establishing Judd Publishing as the administrator and thus the responsible party for claims like the ones in this case. The provision to which Plaintiff refers reads, "A monthly administration fee will be charged in addition to premiums. Administration charges may be changed by the Company from time to time by written notice to the Employer."[9] Plaintiff contends this provision and the fact that Benicorp actually administered the Plan shows Benicorp was the official 'administrator' as defined by ERISA. Plaintiff contends that Benicorp's attempt to limit its liability should preclude Benicorp from relying on the protections of ERISA.[10] After carefully considering the arguments of both parties and the applicable law, the Court makes the following findings of law.

II. Summary Judgment Standard

"Under Rule 56(c), summary judgment is proper 'if the pleadings, depositions, answers to interrogatories, and...the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.'" Celotex v. Catrett, 477 U.S. 317, 322 (1986). "In our view, the plain language of Rule 56(c) mandates the entry of summary judgment ... against

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[8] R. at 46, p. 3 (Pl.'s Summ. J. Resp.).

[9] R. at 43, Ex. D, p.3.

[10] Although the question of who is the administrator of the Plan has been argued by both parties, that issue is not reached here because it is not relevant to the resolution of the matters decided in this order.

a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial."

"Rule 56(e) ... requires the nonmoving party to go beyond the pleadings and by her own affidavits, or by the 'depositions, answers to interrogatories, and admissions on file,' designate 'specific facts showing that there is a genuine issue for trial." Id. "Issues of fact are 'genuine' only if a reasonable jury considering the evidence presented could find for the nonmoving party." Anderson v. Liberty Lobby Inc., 477 U.S. 242, 249 (1986). The burden on the movant may be discharged "by 'showing' – that is, pointing out to the district court – that there is an absence of evidence to support the nonmoving party's case." Celotex, 477 U.S. at 322. "Summary judgment procedure is properly regarded not as a disfavored procedural shortcut, but rather as an integral part of the Federal Rules as a whole, which are designed 'to secure the just, speedy and inexpensive determination of every action.'" Id. at 327 (citation omitted).

III. Discussion

In ERISA, Congress set out to "protect ... participants in employee benefit plans and their beneficiaries ... by providing for appropriate remedies, sanctions, and ready access to the Federal Courts." Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 44 (1987) (citing 29 U.S.C. § 1001 (b)) (employee's common law breach of contract and tort claims against insurer preempted by ERISA). "ERISA comprehensively regulates, among other things, employee welfare benefit plans that, 'through the purchase of insurance or otherwise,' provide medical surgical, or hospital care, or benefits in the event of sickness, accident, disability or death." Id. (citing 29 U.S.C. § 1002(1)). "Except as provided in subsection (b) of this section, the provisions of this [statute] shall supersede any and all State laws

insofar as they may now or hereafter relate to any employee benefit plan." Id. (citing § 514(a), 29 U.S.C. § 1144(a)). The "express pre-emption provisions of ERISA are deliberately expansive, and designed to establish pension plan regulation as exclusively a federal concern." Id. at 45 (citations and internal quotations omitted). Common law causes of action "based on alleged improper processing of a claim for benefits under an employee benefit plan, undoubtedly meet the criteria for pre-emption." Id. at 48. Section 502(a), as set forth in 29 U.S.C. § 1132(a), provides that civil actions may be brought by a participant or beneficiary to recover benefits due under the terms of his plan, to enforce rights under the plan, to clarify rights to future benefits under the plan, to enjoin any act or practice which violates any ERISA provision or to obtain other appropriate equitable relief. Id. at 54 n.3. "Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits, and that varying state causes of action for claims within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress." Id. at 52. "The conclusion that § 502(a) was intended to be exclusive is supported, first, by the language and structure of the civil enforcement provisions, and second, by legislative history in which Congress declared that the pre-emptive force of § 502(a) was modeled on the exclusive remedy provided by § 301 of the Labor Management Relations Act, 1947 (LMRA), 61 Stat. 156,29 U.S.C. § 185." Id. "The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." Id. at 54. The "civil enforcement

provisions found in § 502(a) ... provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." Id.

"In order to have an ERISA plan there must be (1) a plan, fund or program (2) established or maintained (3) by an employer or by an employee organization (4) for the purpose of providing, among other things, medical or death benefits (5) to participants and their beneficiaries." Glass v. United of Omaha Life Ins. Co., 33 F.3d 1341, 1345 (11th Cir. 1994) (citing Donovan v. Dillingham, 688 F.2d 1367, 1371 (11th Cir.1982)). A party's state law claim 'relates to' an ERISA benefit plan for purposes of ERISA preemption whenever the alleged conduct at issue is intertwined with the refusal to pay benefits. Garren v. John Hancock Mut. Life Ins. Co., 114 F.3d 186 (11th Cir. 1997) (citing Farlow v. Union Cent. Life Ins. Co., 874 F.2d 791 (11th Cir. 1989) (plaintiffs' state law claims are preempted where the allegedly improper conduct was intertwined with the refusal to pay benefits)). Finally, the only available remedies for ERISA claims are found in § 502(a)(3). The court of appeals has explicitly held that "extra-contractual damages are not available under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3)." McRae v. Seafarers' Welfare Plan, 920 F.2d 819, 821 (11th Cir. 1991); see also Hunt v. Hawthorne Associates, Inc., 119 F.3d 888, 908 (11th Cir. 1997) (legal relief in the form of a money judgment under section 502(a)(1)(B) is not available). "Relief may take the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits." Pilot Life, 481 U.S. at 53.

In the case at bar, the Plan under which Mr. Williams was covered was clearly a plan established by and funded by his employer Judd Publishing for the purpose of providing, among other things, medical benefits. Plaintiffs claims clearly 'relate' to the Plan and are therefore all

preempted by ERISA. The only remedies available are those provided by ERISA. However, Plaintiff contends that because Defendant Benicorp attempted to limit its liability in certain provisions of the Plan it should be equitably estopped from seeking the protections of ERISA.

The doctrines "of waiver or estoppel cannot be given the effect of enlarging or extending the coverage as defined in the contract, nor can it create a contract of insurance, since a cause of action cannot be based on a waiver." Kane v. Aetna Life Ins., 893 F.2d 1283, 1285 n.3 (11th Cir. 1990) (citing 18 M. Rhodes, Couch Cyclopedia of Insurance Law § 71:40 (Rev. ed. 1983)). In Kane, the court applied equitable estoppel because an employee of the insurance company made oral representations to the insureds that their child was covered under the plan. The parents then incurred large medical bills for which the company later denied coverage. The court found the insurance company was equitably estopped from denying coverage. That interpretation is clearly distinguishable from the case at bar where the insurance company has consistently maintained the lung transplant is not covered by the policy in question.

A later case found that equitable estoppel may only be used "when the employee relies to his detriment on an interpretation of an ambiguous provision in a plan by a representative of that plan." Katz v. ALLTEL Corp., 985 F.Supp. 1157, 1161 (11th Cir. 1997) (citing Kane, 893 F.2d at 1285-65). "The Eleventh Circuit set forth the following elements of equitable estoppel, as defined by federal common law: (1) the party to be estopped misrepresented material facts; (2) the party to be estopped was aware of the true facts; (3) the party to be estopped intended that the misrepresentation be acted on or had reason to believe the party asserting the estoppel would rely on it; (4) the party asserting the estoppel did not know, nor should it have

known, the true facts; and (5) the party asserting the estoppel reasonably and detrimentally relied on the misrepresentations." Id. (citation omitted). "The Supreme Court [has held] that the authority of courts to develop ERISA federal common law is not the authority to revise the text of the statute." Id. (citing Mertens v. Hewitt Associates, 508 U.S. 2, 48, 259 (1993)). A plaintiff is required "to identify one of the enforcement provisions in § 502(a) that authorizes the recovery of damages on their ERISA claim." Id. Section 502(a)(3) does not provide statutory authority for an equitable estoppel claim when plaintiffs are seeking compensatory damages. Id.

Plaintiff Williams has not identified any of the provisions in § 502(a) as authority for the recovery of monetary damages for her equitable estoppel claim. Even assuming the Plaintiff had done so, her equitable estoppel claim is barred because she is seeking monetary damages. Because monetary damages do not constitute 'appropriate equitable relief under § 502(a), Plaintiffs equitable estoppel claim is not permitted under ERISA. Further, there was no detrimental reliance by Plaintiff Edna Williams or Mr. Williams on any representations by any employee or agent of Benicorp that somehow led the Williams to believe a lung transplant would be covered under the Plan. Equitable estoppel may not be used to enlarge the coverage otherwise specifically provided for in the Plan or to allow a recovery not available in the Plan or in ERISA's legislative framework.

Regrettably, there is simply no remedy available to Plaintiff Williams because ERISA does not provide for legal, or monetary, *damages*. Extra-contractual damages are not available under ERISA. The only available remedies are found in § 502(a)(3). Plaintiff Williams seeks to recover compensatory damages from Defendant Benicorp based on its alleged mishandling of Mr. Williams' request for

benefits. This claim does not seek to clarify future rights under the Plan, to recover benefits due and owing under the Plan or to enforce rights otherwise available under the Plan. As explained in Pilot Life, *supra*, a claim for the mishandling of benefits is clearly an ERISA-preempted claim.

Even if Plaintiff's claims somehow stated a cause of action under ERISA, Plaintiff is barred from bringing them because she failed to pursue her administrative remedies. The court of appeals has consistently held "that the exhaustion requirement applies both to actions to enforce a statutory right under ERISA and to actions brought to recover benefits under a plan." Counts v. American General Life and Acc. Ins. Co., 111 F.3d 105, 109 (11th Cir. 1997) (citing Springer v. Wal-Mart Associates' Group Health Plan, 908 F.2d 897, 899 (11th Cir.1990)); Mason v. Continental Group, Inc., 763 F.2d 1219, 1225-27 (11th Cir.1985)). Plaintiff failed to pursue *any* administrative remedies whatsoever prior to bringing this suit. Therefore, Plaintiffs claims are procedurally barred. See Perrino v. Southern Bell Telephone & Telegraph Co., 209 F.3d 1309, 1315-16 (11th Cir. 2000) (requiring exhaustion prior to bringing an ERISA claim in federal court); Mason v. Continental Group, Inc., 763 F.2d 1219, 1227 (11th Cir. 1985) (same). Further, the facts of this case do not warrant an exception to the exhaustion requirement. There is no evidence that an administrative scheme was unavailable - one in fact was, that pursuing administrative remedies would have been futile or that the remedy would have been inadequate.[11]

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[11] Plaintiff claims as an alternative remedy that Defendant should be penalized pursuant to 29 U.S.C. §§ 1132(c) and 1024(b)(4) for its delay in furnishing the Plan documents when requested. Plaintiff s counsel did not request the documents until October 11, 2001, nearly two years after Mr. Williams passed

Perrino, 209 F.3d at 1318.

Although Plaintiff contends that leaving her without a remedy under these circumstances is unreasonably harsh and unjust, the findings of law in this case are dictated by Congress' comprehensive legislation in ERISA and precedent from this circuit and the Supreme Court. Congress developed ERISA as the single enforcement and remedial mechanism to address claims that a plan administrator mishandled a benefit request. The administrative remedies available under ERISA plans are there to protect the interests of insureds and the plan's proceeds. Mandating exhaustion of those remedies protects the plan assets for future benefit claims by plan participants and beneficiaries. Tragically, Plaintiff Williams lost her husband before the transplant process could get underway in this case. However, under ERISA and applicable case law there are simply no available remedies for Plaintiffs claims. Accordingly, Defendant's Motion for Summary Judgment must be and is GRANTED.

Defendant's Motion to Strike certain portions of Plaintiffs statement of material facts remaining to be tried is dismissed because the findings in this order rely on the undisputed facts in the record as a whole.

SO ORDERED this 15th day of January, 2003.

Wilbur D. Owens, Jr.
United States District Judge

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away. R. at 40, Ex. 4. Clearly, the documents were requested well outside the period for seeking administrative review. This claim may not be used as a basis for excusing Plaintiff from exhausting her administrative remedies.

Appendix C
Statutory Provisions

1. Section 1132 of Title 29 of the United States Code states in relevant part as follows:

Sec. 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought -

(1) by a participant or beneficiary -

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under

paragraph (2), (4), (5), or (6) of subsection (c) of this section or under subsection (i) or (l) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (I) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

* * * * * * *

2. Section 1144 of Title 29 of the United States Code states in relevant part as follows:

Sec. 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the

provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

* * * * * * *

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * * * * * *

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

* * * * * * *

Appendix D
Complaint as Amended

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

EDNA L. WILLIAMS,

Plaintiff,

v.

Civil Action No.

5:01-CV-0508-1

BENICORP INSURANCE COMPANY, BOSWORTH & ASSOCIATES, INC., and JOHN DOE and JOHN DOE CORPORATION,

Defendants.

PLAINTIFF'S FIRST AMENDMENT TO COMPLAINT

Edna L. Williams amends her complaint by restating it as follows:

1. Edna Williams is the surviving spouse of James F. "Frank" Williams.

2. (a) Defendant Benicorp Insurance Company (hereinafter "Benicorp") is an insurance company with a principal place of business in Indianapolis, Indiana. Benicorp transacts business in Georgia and is subject to the jurisdiction of this court.

(b) Defendant Bosworth & Associates, Inc., (hereinafter "Bosworth") is a Georgia corporation with its principal place of business in Macon, Georgia and is subject to the

jurisdiction of this court.

(c) Defendants John Doe and John Doe Corporation are one or more persons or corporations that may be responsible for the death of James F. Williams.

3. At all times pertinent to this case, defendant Bosworth was an independent agent authorized to transact business on behalf of defendant Benicorp.

4. Venue is proper in the state court from which this case was removed pursuant to OCGA § 33-4-1(2), OCGA § 14-2-510, and Georgia Constitution Article VI, Section II, Paragraph IV.

5. (a) At all times pertinent to this suit, Benicorp held itself out as engaged in the business of insurance.

(b) Benicorp issued a group health insurance policy, numbered 97244044, to Judd Publishing Company, Inc. (hereinafter "Judd Publishing"), a corporation with a business located at 4853 Eisenhower Parkway in Macon, Georgia.

6. James F. Williams was an employee of Judd Publishing and was covered under the group health insurance policy by virtue of certificate number 2548051260.

7. The group health insurance policy was effective at all times pertinent to this suit. It covered major medical benefits and included a Rider amending Item M of the Major Medical Benefits Section. As amended, the policy covered:

> M. Human Organ/Tissue Transplants or replacement. The following procedures only will be covered on the same basis as any other sickness: ...
>
> 8.. Heart and lung transplants ...

8. On or about October 12, 1999, James F. Williams was diagnosed as being at the end stages of pulmonary fibrosis disease and recommended for a lung transplant at the

Kirkland Clinic at the University of Alabama at Birmingham.

9. (a) Defendant Bosworth, through its agents and employees, undertook to provide all documentation needed by defendant Benicorp to determine whether the group policy covered Mr. Williams's transplant.

(b) Benicorp asserts that it did not get sufficient information to consider whether Mr. Williams's transplant would be covered.

10. Despite requests to Benicorp to pre-certify Mr. Williams for a lung transplant, Benicorp denied coverage because its policy covered heart and lung transplants, but not lung transplants alone.

11. After Benicorp denied coverage, plaintiff Edna Williams began to prepare paperwork to get state monetary assistance to pay for the needed transplant, since Benicorp denied coverage. The paperwork required Benicorp to state in writing why it was denying coverage. Benicorp stonewalled requests to provide a written reason for denying coverage, thereby interfering with plaintiff's efforts to obtain state funds for the needed operation.

12. On or about November 16, 1999, in response to Edna Williams's stated intent to publicize Benicorp's interpretation of its contract, Benicorp began to reconsider its position that the policy did not cover lung transplants.

13. On November 18, 1999, Benicorp wrote a letter to Mr. Williams stating that Benicorp would cover his lung transplant.

14. Hours later, James F. Williams died due to his lung disease.

15. If Benicorp had approved the lung transplant for Mr. Williams at an earlier date, Mr. Williams could have been placed on an oxygen ventilator in a controlled environment until a lung would become available for transplant.

Count One - Claims Under Georgia Law

16. As a result of the foregoing facts, Benicorp is responsible for the wrongful death of James F. Williams under the provisions of OCGA § 51-1-48 because it did not exercise ordinary diligence to administer the transplant benefits under the subject group health insurance policy in a timely and appropriate manner. The terms of OCGA § 51-1-48 also became part of the contractual terms of every policy of a managed care plan issued, issued for delivery, delivered, or renewed on or after July 1, 1999. The grievance procedure described in OCGA § 33-20A-5 is unnecessary because the harm to James F. Williams has already occurred, and the grievance procedure would be untimely and pointless because the harm has occurred and because Benicorp has conceded that the lung transplant would have been covered.

17. Defendant Benicorp is responsible for the wrongful death of James F. Williams because it interfered with the plaintiff's efforts to obtain state coverage for a needed lung transplant.

18. Defendants Bosworth and John Doe and John Doe Corporation are or may be liable for the wrongful death of James F. Williams due to their negligence in communicating information between Benicorp and Mr. Williams, Mrs. Williams, their physicians, and others acting on their behalf. Benicorp is or may be liable vicariously for the acts of defendant Bosworth, John Doe and John Doe Corporation as agents of Benicorp.

19. Benicorp has presented an insurance policy that it claims to be governed by the Employment Retirement Income Security Act of 1974 ("ERISA"). See Tab A attached to Affirmation of Julia Summers. This will be called the "Benicorp Master Policy." That policy is not governed by ERISA, however, because:

(a) Judd Publishing did not establish or maintain that policy.

(b) (1) Under the terms of the Benicorp Master Policy, Benicorp is the exclusive administrator of the policy. (Tab A, pp. 24-26.) According to the policy, Benicorp "shall have full, final and conclusive discretionary authority to determine all questions and issues regarding the administration and interpretation of the Policy," which specifically includes eligibility for benefits, interpretation of policy terms, determination of any of the claimant's rights under the policy, and factual matters relating to the exercise of this discretionary authority. (Tab A, p. 26.) If this were an ERISA plan, Benicorp would be the administrator under 29 U.S.C. § 1002(16)(A)(i) and as defined in Hamilton v. Allen-Bradley Co., Inc., 244 F.3d 819 (11th Cir. 2001).

(b) (2) Judd Publishing has no right to administer this policy.

(b) (3) The "Employer Agreement & Application" (Tab D, p. 3) states under the topic "Compliance with Employment Laws" that "neither the Company [Benicorp] nor the Trust/Policyholder [Benicorp Insurance Company Employee Benefits Trust] is acting as a plan sponsor or plan administrator, as defined in [ERISA]." As a result, both Benicorp and Judd Publishing understood and agreed that the Benicorp Master Policy is not a plan governed by ERISA.

(b) (4) Benicorp should be estopped to assert that its policy is a plan governed by ERISA in view of the facts set out in the preceding paragraph.

20. Judd Publishing did not establish or maintain an ERISA plan because:

(a) Judd Publishing did not intend to establish an ERISA plan. On the contrary, Judd Publishing simply intended to subsidize the purchase of health insurance coverage at lower group rates.

(b) Judd Publishing did not establish or maintain any

ERISA plan "pursuant to a written instrument," as required by Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 72, 83 (1995).

(c) Judd Publishing did not name a fiduciary as a fiduciary with authority to manage and control such a plan, as required by § 1102(a)(1) and (2) for ERISA plans.

(d) Judd Publishing did not create, or provide to Mr. or Mrs. Williams, the Summary Plan Description containing the information required in § 1022 that must be furnished for ERISA plans under 29 U.S.C. § 1021(a) and § 1024(b).

(e) Judd Publishing did not file with the Secretary of Labor the annual report containing information required by § 1023, as required by § 1021(b) for ERISA plans.

(f) Judd Publishing did not establish a written plan providing a procedure for establishing and carrying out a funding policy, or a procedure for allocation of responsibilities for the operation and administration of the plan, or for amending the plan, or for identifying the persons with authority to amend the plan, or for specifying the basis on which payments are made to and from the plan, as required by § 1102(b) for ERISA plans.

21. ERISA does not apply to this claim because the standards of conduct established by the state of Georgia regulate insurance within the meaning of 29 U.S.C. § 1144(b)(2)(A), and UNUM Life Insurance Co. v. Ward, 526 U.S. 358 n. 7 (1999).

22. WHEREFORE, plaintiff seeks to recover the full value of the life of James F. Williams, her expenses of litigation, including reasonable attorney's fees, and such other relief as is just and proper. Benicorp should be estopped from asserting, contrary to its agreement with Judd Publishing, that the policy it administers is an ERISA plan.

COUNT TWO - ERISA CLAIMS

23. In the alternative, in case the Court finds that the

subject policy is governed by ERISA, plaintiff states the following claims:

24. (a) The policy expressly incorporates the provisions of Georgia state law. It states that "if, on the effective date, any part of this Policy is in conflict with the state statutes relating to insurance of the state where it is delivered, then it is automatically amended to meet the minimum requirements of the statutes." (Tab A, p. 16) Other parts of the policy recognize that Georgia regulates the content of this policy (Tab A, pp. 60-61, and various riders).

(b) The policy lacks a single "effective date" for the entire policy. The policy's "Effective Date" definition refers to eligibility for employees.

(c) OCGA § 51-1-48 became effective on July 1, 1999. It is a statute relating to insurance in Georgia.

(d) Under the terms set forth above, if any employee in Georgia became eligible to participate in this policy between July 1, 1999 and October 12, 1999, the policy would have been automatically amended to comply with the requirements of OCGA § 51-1-48.

(e) On information and belief, plaintiff asserts that some Georgia employee became a participant in this master policy between July 1, 1999 and October 12, 1999.

(f) The policy, as automatically amended, thereby incorporated the provisions of OCGA § 51-1-48, its standards of conduct, and the benefits (damages in tort) it provides, by the contractual terms of this policy, on the date on which Mr. Williams sought a lung transplant.

(g) Under this provision of the ERISA plan, as automatically amended, plaintiff is entitled to recover for the full value of the life of Mr. Williams as a contractual benefit of the ERISA plan.

25. (a) Under the terms of the ERISA plan, Mr. Williams would have been entitled to receive the benefit of insurance coverage for a lung transplant, as well as associated

medical services before and after the transplant.

(b) By refusing to pay such benefits, Benicorp was unjustly enriched by retaining the funds that would have been paid to the medical service providers who would have provided the transplant and associated medical services.

(c) Under 29 U.S.C. § 1132(a)(1)(B) and § 1132(a)(3), plaintiff is entitled to recover the sums by which Benicorp was unjustly enriched.

26. (a) For reasons stated above, Benicorp was the administrator of this alleged ERISA plan.

(b) On October 11, 2001, Plaintiff requested in writing from Benicorp various plan documents that it was required to provide upon request under 29 U.S.C. § 1024(b)(4).

(c) On November 8, 2001, Benicorp responded, but failed to provide the requested documents.

(d) On April 3, 2002, Benicorp provided some but not all of the documents requested.

(e) Under 29 U.S.C. § 1132(a)(1)(A) and § 1132(c), the Court may award an amount up to $100 per day from 30 days after the date of the request.

27. Under 29 U.S.C. § 1132(g), the Court may award reasonable attorney's fees and costs.

28. WHEREFORE, if the Court finds that this policy is an ERISA plan, plaintiff respectfully prays for (a) the full value of the life of Mr. Williams as a benefit of the policy, (b) the amount by which Benicorp was unjustly enriched as a result of its refusal to pay for the lung transplant, (c) an appropriate sum in the Court's discretion in view of Benicorp's failure to comply with the law requiring it to provide plan documents upon request, and (d) reasonable attorney's fees and costs.

RESPECTFULLY SUBMITTED, this April 19, 2002.

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Appendix E
Excerpts from the Administrative Record

1. The following are excerpts from the notes of Robin Clark, Benicorp's Care Manager for Mr. Williams.

Reporter: Trina/Transplant Coord.
Care Manager: Robin Clark
Date: 10/14/1999

Trina called back about this case. States she is the transplant coordinator and she has given the info to Lexi to schedule all of transplant work up testing. Informed her that Barb Rouse had called to say he did not have lung transplant benefit. Gave her Barb's number since we do not quote benefits. She will have Judy Luman (SW) call Barb and then will get back to me with the plan. States they will hold off on the 3-5 days of work up testing till find out what the status is on benefits. Does not know what they do in a case where Pt. does not have benefit. States Judy Luman will handle this and be in touch with me.//RMC

Reporter: Angela/Financial Coord.
Care Manager: Robin Clark
Date: 10/15/1999

Angela called and states she did talk to Barb at Benicorp and James does not have transplant benefit. States he is from another state of possibly something could be worked out. She will have the SW, Judith, call me in regards to trying to possibly get him referred in his own state for possible transplant or to see what the situation is.//RMC

Reporter: Judy Luman/Lung Transplant
Care Manager: Robin Clark
Date: 10/18/1999

Judy called back late this PM and states she will call the Pt. and try to refer him to Emory University in GA since has no transplant coverage and is coming to them from GA. She will let me know if referral made.//RMC

Reporter: Home Machine
Care Manager: Robin Clark
Date 10/29/1999

T/C to the home and requested call back to F/U on how he is doing with the 02 and what has been found about potential for transplant.//RMC

Reporter: Mrs. Williams
Care Manager: Robin Clark
Date: 10/29/1999

Mrs. Williams called back and states * * * she talked to transplant coordinator and they are to be getting in touch with them to try to get this organized. She will call me back as soon as she hears from them.//RMC

Reporter: Judy Luman/SW at Transplant
Care Manager: Robin Clark
Date: 11/1/1999

T/C to Mr. Williams this a.m. to see if has gotten conserving

device yet. He thinks this is being delivered today. Did not go to work today due to feeling SOB. Suggested he call me to see if they can do any med. adjustment. He states he is still waiting call back from Birmingham Transplant Center about date for testing. However, Judy and Benicorp have both told me previously pt. did not have transplant benefit. Judy was going to try to look into getting pt. set up to see someone at Emory about transplant in his own state. Have called Judy and left VM msg. Requesting f/u call back about this at 205-975-8610.//RMC

Reporter: Judy Luman (SW AT Transplant
Care Manager: Robin Clark
Date: 11/4/1999

Judy Luman called and left VM msg. On 11/3 that she was getting ready to call James and talk to him about the fact that his ins. does not have coverage for transplant. States their transplant Drs. are planning to get in touch with Mr. Williams referring Dr. to have hopefully have [sic] him referred to Emory Transplant Center hoping that his home state will have some resources available to him to facilitate the needed lung transplant. Will try to reach Pt. at first of next week after has hopefully got conserving device and has heard from transplant team.

Reporter: Mrs. Williams
Care Manager: Robin Clark
Date: 11/10/1999

Mrs. Williams called on 11/9 and left VM msg. That they were told that James does not have transplant benefit (this was from the Birmingham Transplant Team). She wants to

know why. Have referred her to Kristin at Benicorp. Also asked if they have been referred to Emory University for possible transplant within their own state and that might be paid for by some other program other than Benicorp. She wants to talk to Benicorp first about this and then will f/u on the Emory situation. States they are "putting some kind of oxygen thing in James throat today". (I think TTO). Reassured he will cont. to f/u in case management.//RMC

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2. The following is the text of the November 16, 1999, letter from Benicorp to Susan Brown, the insurance agent, regarding Mr. Williams:

Dear Susan:

I am in receipt of the information you faxed to Benicorp today regarding potential transplant coverage for Mr. James Williams. The reaction from the group is rather surprising, considering the fact that Benicorp has not yet even received from Mr. Williams' health care providers a formal predetermination of benefits for a lung transplant for Mr. Williams, nor any specific medical documentation from his attending physicians. At this point, Benicorp has only answered questions from telephone inquiries made by the agent and group contact regarding coverage for this procedure.

The policy plainly states only those transplant procedures expressly set forth therein are covered. To date, Benicorp has simply quoted the certificate benefits, which state that "heart" and "heart and lung" transplants are covered benefits under the Human Organ/Tissue Transplant or Replacement provision. Lung transplants alone are not listed as a covered procedure.

The recent issue which you brought to our attention

certainly raises a question of contractual interpretation, and it is a question we intend to review carefully. Obviously, it will take Benicorp a few days to thoroughly and accurately review the documentation relating to Mr. Williams' claim. Therefore, we are asking for a bit of patience on the group's part to allow us to conduct the research necessary to make the correct decision.

We also would ask that the group deal with us directly in the future regarding this matter, so that your agency isn't being put in the uncomfortable position of being in the middle.

You and the group will hear form us in a few days with our determination regarding Mr. Williams' proposed lung transplant. In the interim, if you should have any questions, please contact me.

Sincerely,
Barbara A. Rouse
Vice President of Group Operations

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3. The following is the text of the November 18, 1999, letter from Benicorp to Mr. Williams:

Dear Mr. Williams:

This is a follow-up to Ms. Barbara Rouses' [sic] letter of November 16, 1999 (enclosed), which was sent to Susan Brown at Bosworth and Associates. As Ms. Rouse discussed in her letter, the information submitted through Bosworth & Associates raised a contractual interpretation we have reviewed.

Subject to all of the terms and conditions of coverage with Benicorp Insurance Company, Benicorp will cover, under your organ transplant benefit, a lung transplant performed without a heart transplant.

I have notified our utilization review company and asked them to contact your physicians to resume their activities related to your transplant.

Should you have any questions, please feel free to contact myself or Ms. Rouse.

Sincerely yours,
Brian Boje
Executive Vice President

No. 03-786

IN THE

Supreme Court of the United States

EDNA L. WILLIAMS,

Petitioner,

v.

BENICORP INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether § 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a), completely preempts a state law tort claim seeking damages for an alleged delay in providing notice of a determination of entitlement to a benefit under an ERISA-governed insured health benefit plan.

Whether § 514 of ERISA, 29 U.S.C. § 1144, also preempts a state law tort claim seeking damages for an alleged delay in providing notice of a determination of entitlement to a benefit under an ERISA-governed insured health benefit plan.

STATEMENT PURSUANT TO RULE 29.6

The parent of Benicorp Insurance Company is Benicorp Financial, Inc. There is no publicly held company that owns 10% or more of Benicorp Insurance Company or Benicorp Financial, Inc.

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STATEMENT OF JURISDICTION

The district court had federal question jurisdiction over the plaintiff's claims pursuant to 28 U.S.C. § 1331 and the complete preemption effected by 29 U.S.C. § 1132. The court of appeals asserted jurisdiction over the district court's final judgment pursuant to 28 U.S.C. § 1291. The judgment of the court of appeals was entered on August 26, 2003. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTES AND CONSTITUTIONAL PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution provides: "This Constitution, and the laws which shall be made in pursuance thereof . . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any thing in the Constitution or laws of any State to the contrary notwithstanding." U.S. Const., art. IV, cl.2. The pertinent provisions of ERISA, 29 U.S.C. § 1001, *et seq.*, are set forth in the appendix to the Petition for Writ of Certiorari. (Petitioner's Appendix "Pet. App." C at 14a-16a)

COUNTER STATEMENT OF THE CASE

Respondent, Benicorp Insurance Company ("Benicorp"), is an insurance company licensed to transact business in twenty-eight (28) states, including the state of Georgia. Benicorp sells group major medical indemnity insurance coverage to employer-sponsored groups in nine (9) states. In connection with the indemnity insurance coverage, Benicorp has no arrangements in Georgia with any selected providers to furnish or deliver healthcare services. Benicorp

has no contracts with healthcare providers in the state of Georgia. Benicorp does not select healthcare providers for its insureds' in the state of Georgia. Benicorp is not and has never operated as a health maintenance organization. Benicorp does not act in any capacity as a "gatekeeper" whereby Benicorp could make determinations regarding an insured's access to a particular healthcare provider or a particular medical procedure or treatment. Benicorp does not maintain an exclusive provider arrangement in connection with its indemnity coverage issued in the state of Georgia. Benicorp is not, and has never been, certified as a managed care entity as that term is defined at Ga. Code Ann. § 33-20A-4. Benicorp is not, and never has been, subject to the reporting requirements for managed care entities contained at Georgia Comp. R. & Regs. 120-2-8-.05. (Respondent's Appendix "Resp. App." at 2a-5a)

Petitioner, Edna L. Williams ("Mrs. Williams"), and her late husband, James Williams, were employed with Judd Publishing Company ("Judd Publishing"). Judd Publishing sponsored an ERISA employee welfare benefit plan (the "Judd Publishing Plan") which offered a group health plan to its employees. (Court of Appeals Record "C.A. Record" Vol. 2, Doc. 40, Tab 2, p. 6) Beginning in 1997, Benicorp provided group indemnity coverage for the medical and life insurance components for the Judd Publishing Plan. (Resp. App. at 3a)

Mrs. Williams alleges that on October 12, 1999, Mr. Williams was diagnosed with pulmonary fibrosis disease and his physicians recommended he undergo a lung transplant. (Pet. App. D at 18a) Mrs. Williams alleges that Mr. Williams called the Care Manager who handles claims for Benicorp, Robin Clark, and informed her that he was

going to be tested for a potential transplant. (Pet. App. B at 4a) Mrs. Williams also alleges that Ms. Clark then called Barb Rouse, the Vice President of Group Operations for Benicorp, to notify her of the potential transplant. (Pet. App. B at 4a) Mrs. Williams further claims that Ms. Rouse called Ms. Clark back the following day and informed Ms. Clark that there was no coverage for a lung transplant alone. (Pet. App. E at 26a) Mrs. Williams then states that Mrs. Clark called Trina Smith, the transplant coordinator at Kirklin Clinic where Mr. Williams was scheduled for testing for the potential transplant and informed her that Mr. Williams did not have coverage through Benicorp for the potential transplant. (Pet. App. B at 5a)

In her Petition, Mrs. Williams concedes that within days of Mr. Williams making inquiry regarding coverage for a lung only transplant, the transplant coordinator at his healthcare facility was informed that Benicorp did not provide coverage for the procedure. (Pet. at 2) Mrs. Williams also acknowledges that by October 18, 1999 (six (6) days after Mr. Williams' diagnosis), "the Alabama hospital's social worker stated to Ms. Clark that she [the social worker] would begin efforts to refer Mr. Williams to Emory University in Georgia **since there was no transplant coverage**." (Pet. at 3) (emphasis added).

Mrs. Williams claims that despite Benicorp's denial of the lung transplant benefit, Benicorp did not timely inform Mr. Williams in writing or by telephone of its denial. (Pet. App. D at 19a) There is no evidence from Mrs. Williams that she or Mr. Williams ever submitted a notice of claim or proof of loss or that they sought to invoke the claim review procedure as set forth in the Certificate Book or policy.

Mrs. Williams commenced this action in the State Court of Bibb County, Georgia under Civil Action No. 50976 naming Benicorp and others as defendants (the "Bibb County Action"). In Mrs. Williams' Complaint, she alleged state law claims of wrongful death, negligence, violation of Ga. Code Ann. § 51-1-48 (the "Georgia Statute"), tortious interference, and vicarious liability. (C.A. Record Vol. 1, Doc. 1, p. 10) On December 19, 2001, Benicorp filed a Notice of Removal to remove the Bibb County Action to the United States District Court for the Middle District of Georgia, Macon Division because all the claims related to a welfare benefit plan under ERISA. (C.A. Record Vol. 1, Doc. 1, pp. 1-7)

On April 22, 2002, Mrs. Williams amended her Complaint to add claims under ERISA. In addition to the same state law claims, Mrs. Williams alleged a claim for unjust enrichment under ERISA 29 U.S.C. § 1132(a)(1)(B) and § 1132(a)(3), and that Benicorp failed to provide Mrs. Williams copies of the plan documents upon request pursuant to 29 U.S.C. § 1024(b)(4) of ERISA. (Pet. App. D at 24a)

On October 15, 2002, Benicorp moved for summary judgment on all of Mrs. Williams' claims. (C.A. Record Vol. 2, Doc. 38, p. 1) The district court granted summary judgment in Benicorp's favor on January 15, 2003. (Pet. App. B at 3a) The district court determined that ERISA preempted Mrs. Williams' state law claims. (Pet. App. B at 9a-10a) The district court also held that no remedy was available to Mrs. Williams under ERISA because she was seeking monetary damages which did not constitute "appropriate equitable relief" provided for under ERISA. (Pet. App. B at 11a) The district court further concluded that even if Mrs. Williams could state a cause of action under ERISA, she had failed to exhaust her administrative remedies prior to bringing her lawsuit. (Pet. App. B at 21a)

On January 27, 2003, Mrs. Williams filed a Motion to Alter or Amend the Judgment (C.A. Record Vol. 2, Doc. 59, p. 1), which was denied by the district court on March 27, 2003. (C.A. Record Vol. 2, Doc. 73, p. 2) On April 25, 2003, Mrs. Williams filed a Notice of Appeal on the district court's January 15, 2003 Judgment. (C.A. Record Vol. 2, Doc. 74, p. 1)

On August 26, 2003, the court of appeals affirmed the district court's judgment. (Pet. App. A at 1a-2a)

REASONS FOR DENYING THE PETITION

This Court has answered the only question presented by Mrs. Williams' Certiorari Petition – whether ERISA preempts a state law tort claim seeking alleged damages relating to the determination of entitlement to benefits under an ERISA-governed plan. Mrs. Williams asks this Court to reverse this long-standing precedent and rule that ERISA does not preempt a state law negligence claim for an alleged breach of an implied duty of good faith and fair dealing by a purported delay in communicating an ERISA plan benefit determination.[1] By her Petition, Mrs. Williams does not challenge the correctness of Benicorp's benefit determination, rather she challenges only the timeliness in communicating that determination to Mr. Williams. (Pet. at 12-13)

---

1. In her Petition, Mrs. Williams characterizes her claim as "negligence" and breach of the "duty of good faith and ordinary care." (Pet. at 5-6) Before the court of appeals, Mrs. Williams characterized her claim as based upon "Georgia's common law rules of insurance bad faith." (Brief of Appellant at 11)

In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), this Court held that ERISA completely preempts state common law tort and contract actions asserting improper processing of claims for benefits under an insured employee benefit plan. Further, in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), this Court held that a state law claim for breach of duty of good faith and fair dealing (among other claims) arising from the termination of employment in order to avoid paying ERISA pension benefits was completely preempted by § 502(a)'s exclusivity. *Id.* at 144-45. Based upon this Court's precedent, Mrs. Williams' state common law tort claim under Georgia law is barred under the complete preemption found in § 502(a) of ERISA.

In addition, Mrs. Williams' state law claim is also preempted by operation of ERISA's express preemption provision found at § 514. Mrs. Williams' state common law tort claim is preempted under the straight-forward application of § 514 and this Court's recent ruling in *Kentucky Association of Health Plans, Inc. v. Miller*, 123 S. Ct. 1471 (2003).

There are no decisions entered by the United States Courts of Appeals that are in conflict with these legal principles as applied to the claim sought to be asserted by Mrs. Williams. The district court and the court of appeals appropriately applied this Court's well-settled legal principles in this matter.

I. Mrs. Williams' state law tort claim that seeks to provide remedies in connection with an ERISA benefit determination is completely preempted under ERISA § 502.

ERISA § 502(a)(1)(B) provides a civil enforcement mechanism for a participant or beneficiary "to recover benefits due . . . , to enforce his rights under . . . , or to clarify his rights to future benefits" under the terms of an ERISA plan. 29 U.S.C. § 1132(a)(1)(B). In *Pilot Life*, this Court held that § 502(a)(1)(B) "provides an exclusive federal cause of action" for a resolution of "a suit by a beneficiary to recover benefits from a covered plan." *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 62-63 (1987) (citing *Pilot Life*, 481 U.S. at 56). The federal cause of action completely preempts any state law claim that seeks to provide different or additional remedies in connection with a benefit determination. This is so, the Court explained in *Pilot Life*, because § 502(a)(1)(B) is part of a:

> comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. 'The six carefully integrated civil enforcement provisions found in § 502 (a) of the statute as finally enacted . . . provide strong evidence that Congress did *not*

> intend to authorize other remedies that it simply forgot to incorporate expressly.'

Pilot Life, 481 U.S. at 54 (quoting *Mass Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)) (emphasis in original).

The Court in *Pilot Life* applied this rule to hold that § 502(a)(1)(B) completely preempted state common law tort and contract actions asserting improper processing of a claim for benefits. The Court recognized that permitting such claims – which would have allowed the plaintiff to recover consequential damages not authorized under ERISA – would upset the careful remedial balance struck in ERISA § 502(a). *Id.* at 50, 54. The Court's critical point was that ERISA § 502(a)(1)(B) must completely preempt state law claims and remedies that are different from the specific claims and remedies that Congress decided to make available in actions relating to benefit determination because state law claims and remedies would disrupt ERISA's comprehensive and uniform system of benefit regulation.[2]

The Court has repeatedly affirmed the analysis adopted in *Pilot Life* and *Metropolitan Life*. In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), the Court unanimously concluded that state law tort claims for breach of duty of

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2. In *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987), in a unanimous decision decided the same day as *Pilot Life*, this Court held that § 502(a)'s preemptive power is sufficient to confer federal jurisdiction over all claims within its scope, including claims plead exclusively under state law. The Court held that *Pilot Life* preemption was sufficient to confer removal jurisdiction. Section 502(a) preempts so completely that it has displaced any parallel state law cause of action, rendering such claims "necessarily federal in character" and sufficient to invoke federal jurisdiction. *Metropolitan Life*, 481 U.S. at 67.

good faith and fair dealing, wrongful discharge and breach of contract were completely preempted by § 502(a)'s exclusivity. *Id.* at 144-45. The Court held that the Texas state law claims for tortious breach of the duty of good faith and fair dealing, wrongful discharge and breach of contract had "patently violate[d]" the uniformity mandated by § 502(a). The Court recognized the conflict in permitting a plaintiff to pursue state law claims for compensatory and punitive damages rather than the recovery of pension benefits and held that ERISA § 502(a) was the exclusive avenue of redress. *Id.*

In *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), the Court recently affirmed *Pilot Life's* holding that ERISA preempts state law causes of action, such as the common law claim asserted by Mrs. Williams, that "add[] to the judicial remedies provided by ERISA." *Id.* at 379. The Court emphasized such causes of action "patently violate ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Id.* Indeed, all members of the Court agreed that if the independent review statute at issue in *Rush Prudential* had created an additional claim or an additional remedy, it would have been preempted under *Pilot Life* and its progeny. *Id.* at 379-80 ("[T]he state statute does not enlarge the claim for benefits beyond the benefits available in any action brought under [§ 502(a)]. This case therefore does not involve the sort of additional remedy exemplified in *Pilot Life*, . . . and *Ingersoll-Rand*. . . ."); *Id.* at 388 (Thomas J., dissenting) (citing *Pilot Life* for the proposition that "as the Court concedes, . . . even a state law that 'regulates insurance' may be preempted if it supplements the remedies provided by ERISA, despite ERISA's savings clause. . . .").

Mrs. Williams seeks to impose state common law tort liability upon Benicorp for allegedly failing to notify Mr. Williams in a timely manner of Benicorp's benefit determination. By her state law claim, Mrs. Williams seeks to challenge under state law the alleged actions of an ERISA fiduciary (Benicorp) in making and communicating an ERISA benefit determination. Mrs. Williams unmistakably seeks to assert a claim for an additional remedy contrary to both § 502(a) and this Court's pronouncements. Her purported state law claim plainly falls within the scope of § 502(a)(1)(B). Specifically, under § 502(a)(1)(B) Mr. Williams could have brought a claim "to clarify his rights to future benefits under the terms of the plan." If Mr. Williams had any question or concern regarding his entitlement to benefits under the Judd Publishing Plan, ERISA § 502(a)(1)(B) provided him an express remedy.[3]

In her Petition, Mrs. Williams argues that recent decisions involving health maintenance organizations and managed care raise a question regarding the application of ERISA complete preemption principles to this case. Mrs. Williams' argument is misguided for at least two reasons. First, Benicorp is a medical indemnity insurer not a managed care entity. Benicorp performed no "gatekeeper" function in connection with Mr. Williams' medical care. In fact, Mrs. Williams acknowledges that Mr. Williams' health care providers understood that he lacked insurance

3. The Department of Labor's new claims procedure regulations underscores that the benefit determination process is an integral part of the claims administration for health and disability plans. *See* 29 C.F.R. § 2560.503-1 (2003). Imposing a patchwork of state law regulation and claims related to the manner and method of communicating benefit determinations would run afoul of ERISA's administrative and civil enforcement mechanisms.

coverage under the Judd Publishing Plan for a lung only transplant and, consequently, sought other financing for the procedure. (Pet. at 3) Second, this case does not raise the issue of "treatment" versus "eligibility" sometimes found in claims concerning managed care entities. There is no issue present in this case that Benicorp in any way influenced Mr. Williams' medical care. In this matter, there is no tension between state negligence law in the health care area and ERISA preemption of matters relating to the administration of ERISA plan benefits. For these and other reasons, there is no reason for the Court to defer ruling on this Petition during the pendency of the Court's consideration of cases involving questions of managed care and medical treatment. *See, e.g., Roark v. Humana, Inc.*, 307 F.3d 298 (5th Cir. 2002), *cert. granted*, 72 USLW 3007, 72 USLW 3299, 72 USLW 3307 (U.S. November 3, 2003) (No. 02-1845).

Numerous circuits have had no difficulty applying the Court's principles to recognize that state law claims related to alleged delay in the administration or determination of ERISA plan benefits are completely preempted under the scope of Section 502(a) of ERISA. *See, e.g., Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 273-75 (3d Cir. 2001) (State law claims for alleged delay in approving benefits falls squarely within ERISA's administrative function and are completely preempted. The plaintiff could have sought an injunction under Section 502(a), thereby using the provisions of the civil enforcement scheme provided by Congress.). *Cicio v. John Does 1-8*, 321 F.3d 83, 94-96 (2d Cir. 2002) (state law claims alleging failure to timely conduct an appeal of a denial of benefits are completely preempted under ERISA as having an effect on the primary administrative functions of benefit plans and within the scope of § 502(a).), *petition for cert. filed on other grounds*, 74 USLW 3093 (U.S. July 11, 2003) (No. 03-69).

II. Mrs. Williams' state law tort claim relates to an ERISA welfare benefit plan and is also preempted under ERISA Section 514.

ERISA supersedes any and all state laws relating to employee benefit plans pursuant to 29 U.S.C. § 1144. ERISA was enacted to provide a comprehensive federal regulatory scheme for employee benefits. *Pilot Life*, 481 U.S. at 44. Thus, ERISA was intended to prevent patchwork enforcement by the various states by providing an express preemption provision that ERISA "shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). This Court has repeatedly noted that this preemption provision is "conspicuous for its breadth." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). In fact, ERISA's comprehensive civil enforcement scheme "would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Id.* at 54. Congress therefore consciously included in ERISA a conspicuously broad and deliberately expansive preemption provision. *Pilot Life*, 481 U.S. at 46, 51-57; *see also Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 64-67 (1987); *FMC Corp.*, 498 U.S. at 58; *Ingersoll-Rand*, 498 U.S. at 138-39.

ERISA's preemption provision states in relevant part that ERISA "supercede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). The Court has emphasized that Congress used the words "relate to" "in their broad sense, rejecting more limited pre-emption language that would have made the clause 'applicable only to state laws relating to specific subjects covered by ERISA.'" *Ingersoll-Rand*, 498 U.S. at 138 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983)). Congress

intended, through the enactment of ERISA, that the field of employee benefit plans be "exclusively a federal concern." *Alessi v. Raybestos - Manhattan, Inc.*, 451 U.S. 504, 523 (1981).

The preemptive scope of ERISA is then limited by the savings clause found at 29 U.S.C. § 1144(b)(2)(A) which provides ". . . nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." The scope and application of the savings clause was most recently addressed by this Court in *Kentucky Association of Health Plans, Inc. v. Miller*, 123 S. Ct. 1471 (2003). In *Kentucky Association*, the Court ruled that in order to survive ERISA preemption under the savings clause, the state law must:

> "be specifically directed toward entities engaged in insurance[4]; and

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4. In *Kentucky Association*, the Court discarded the three-factor McCarran-Ferguson test and developed a two-prong test. The new two-prong *Kentucky Association* test significantly borrows from the factors under the prior McCarran-Ferguson test. This Court transformed the McCarran-Ferguson factors into a new test in order to clarify what requirements must be met in order for the savings clause to apply. This Court made clear that the savings clause analysis was being changed to provide clear guidance to lower courts. 123 S. Ct. at 1478-79.

The first prong under the *Kentucky Association* test is substantially identical to the third factor under the McCarran-Ferguson test, which was "whether the practice is limited to entities within the insurance industry." The first prong under *Kentucky Association* is whether the law is "specifically directed toward entities engaged in insurance. . . ." *Id.* at 1479. Both inquiries focus on whether the law is directed toward entities in the insurance industry. Thus, cases interpreting the third factor in McCarran–Ferguson are instructive and provide guidance as to the first prong of the *Kentucky Association* test.

> "substantially affect the risk pooling arrangement between the insured and insurer."[5]

123 S. Ct. at 1479.

a. Mrs. Williams' tort[6] claim is not saved by the ERISA savings clause.

Mrs. Williams' negligence claim is not saved from ERISA preemption under the savings clause because it does not satisfy either of the two requirements of *Kentucky Association*. First, it is derived from common law and, thus, not specifically directed to insurance entities. Second, it does not substantially affect the risk pooling arrangement between an insured and insurer. For either of these reasons, Mrs. Williams' negligence claim cannot be saved by the ERISA savings clause.

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5. The second prong under the *Kentucky Association* test is substantially similar to the first factor of the McCarran-Ferguson test. The first factor under McCarran-Ferguson is "whether the practice has the effect of transferring or spreading a policyholder's risk." *Id.* at 1478. The second prong under *Kentucky Association* is whether the law "substantially affect[s] the risk pooling arrangement between the insurer and insured." *Id.* at 1479. Due to this similarity, prior cases under the McCarran-Ferguson test provide guidance as to application of the second prong under the *Kentucky Association* test.

6. Prior to her Petition, Mrs. Williams also characterized her common law claim as a "bad faith" cause of action. Though the cited authority remains the same, Mrs. Williams now categorizes the Georgia common law as a negligence claim. Regardless, the analysis under *Kentucky Association* is unaltered.

b. Mrs. Williams' state law claim is not specifically directed to insurance companies because it derives from general common law tort and contract principles.

It is well established that a state law must be "specifically directed toward" the insurance industry in order to fall under ERISA's savings clause; laws of general application that have some bearing on insurers do not qualify. *Pilot Life*, 481 U.S. at 50; *see also Rush Prudential*, 536 U.S. at 366; *FMC Corp.*, 498 U.S. at 61.

This Court in *Pilot Life* held that when a state bad faith law has developed from general principles of contract and tort law, it is not specifically directed to the insurance industry. The Court stated:

> A common-sense view of the word "regulates" would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry. Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law. Any breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law.

481 U.S. at 51. Because all contracts were subject to bad faith claims, the law was not specifically directed to the insurance industry.

An analysis of Mrs. Williams' claim and Georgia law reveal that her purported claim is not "specifically directed" to the insurance industry but rather is the type of common law found to be preempted in *Pilot Life*. A review of Georgia law establishes that Mrs. Williams' claim is based upon general principles of contract and tort law, including breach of the implied duty of good faith and fair dealing which is applied to classes of contracts.

Generally, there is no tort from a breach of contract. *Briarcliff v. Kelley*, 31 S.E.2d 586, 590 (Ga. 1994). *Thomas v. Phoenix Mutual Life Ins. Co.*, 236 S.E.2d 510, 552 (Ga. Ct. App. 1977); *American Oil Co. v. Roper*, 14 S.E.2d 145, 148 (Ga. Ct. App. 1941). However, it is well settled in Georgia that "certain classes" of contracts create a special relationship for which the law then imposes a duty in tort. *Thomas*, 236 S.E.2d at 552. The Georgia Supreme Court held that "[o]nly where such contracts create a legal duty or a relation from which the law implies duties will the breach constitute a tort." *Briarcliff*, 315 S.E.2d at 590; *see also Mimbs v. Commercial Life Ins. Co.*, 832 F. Supp. 354, 359-60 (S.D. Ga. 1993). Even the case of *Hub Motor Co. v. Burdakin*, 386 S.E.2d 854, 855-56 (Ga. Ct. App. 1989), cited by Mrs. Williams, recognizes that in special circumstances a tort will rise from a breach of contract. The Georgia Court of Appeals enunciated this common law rule quite clearly in *American Oil*:

> There are certain classes of contracts which create a relation from which the law implies duties, a breach of which the law implies duties, a breach of which will constitute a tort, and 'in such cases an injured party may sue either for breach of the contract or in tort' for breach of the implied duty.

> This rule applies in certain contractual relations between principal and agent, bailor and bailee, attorney and client, physician and patient, carrier and passenger or shipper, master and servant, and similar well-recognized relations; but it is not every contractual relation which involves a public duty, the breach of which will support an action in tort.

14 S.E.2d at 148; *see also Manley v. Exposition Cotton Mills*, 170 S.E. 711, 711 (Ga. Ct. App. 1933). In *Mauldin v. Sheffer*, 150 S.E.2d 150, 155 (Ga. App. 1966), the Georgia Court of Appeals similarly noted that the law imposes upon "persons of professional standing" an obligation to exercise a reasonable degree of care "such as is ordinarily exercised under similar conditions and like circumstances by persons employed in the same or similar professions." *See also Kaiser Aluminum & Chemical Corp. v. Ingersoll-Rand Co.*, 519 F.Supp. 60, 69 (S.D. Ga. 1981) (Under Georgia law, "professional" relationships can give rise to a duty which exceeds the bounds of the contract itself.); *Howard v. Central of Georgia Ry. Co.*, 71 S.E. 1017 (Ga. App. 1911).

The "professional" implied duty upon which Mrs. Williams' bases her negligence claim arises from common law tort principles. "[T]he duty of the insurance company to use ordinary care and good faith in the handling of a claim against its insured arises out of the relationship between the insurer and the insured created by the contract or policy of insurance. . . ." *Francis v. Newton*, 43 S.E.2d 282, 284 (Ga. Ct. App. 1947). The duty of good faith arises out of the relationship of the insured and insurer. *Metropolitan Property & Casualty Ins. Co. v. Crump*, 513 S.E.2d 33, 34 (Ga. Ct. App. 1999). Where there is no privity of contract or special

relationship, then no action for negligence or bad faith against the insurer may be brought. *Francis*, 43 S.E.2d at 284. It is clear, then, that under Georgia law the negligence claim alleged by Mrs. Williams derives from common law. Numerous professionals share the same "special" contractual relationship in which duties are implied. To be sure, the tort of negligence is of general application and not specifically directed to insurance companies.

In *Moffett v. Halliburton Energy Services, Inc.*, 291 F.3d 1227 (10th Cir. 2002), the Tenth Circuit recently addressed such "special relationships" within the context of ERISA's savings clause. Akin to Mrs. Williams, the plaintiff contended that Wyoming's state law "tort of insurance bad faith" was specifically directed towards the insurance industry and, as such, saved from preemption. Citing this Court's holding in *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999), the plaintiff argued that Wyoming's "tort of insurance bad faith" law was tantamount to California's notice-prejudice rule.[7] The Tenth Circuit disagreed, noting that while the Wyoming tort-based claim may be more narrowly applied than Mississippi's law of bad faith in *Pilot*, it did not "home in" on the insurance industry alone as does California's notice-prejudice law. Like Georgia, Wyoming recognizes "special relationship" torts outside of the insurance context:

> Those limited circumstances include employment cases where a 'special relationship' exists between the employer and the employee, and insurance cases. The Wyoming Supreme Court has noted that [a] special relationship is also an element of

7. California's notice-prejudice rule provided that an insurer must prove prejudice from an insured's failure to give timely notice of a claim in order to enforce its proof-of-claim requirements.

> a tort-based claim in the insurance context, which automatically exists by virtue of the unequal bargaining power the insurer has over an insured.

Moffett, 291 F.3d at 1236 (quoting *Scherer Constr., LLC v. Hedquist Constr., Inc.*, 18 P.3d 645, 652 (Wyo. 2001) (internal citations omitted). Recognizing that its roots were in the general principles of tort and contract law, the Tenth Circuit concluded the "tort insurance of bad faith" is not unique to the insurance industry; rather, it is unique to those settings in which a "special relationship" exists, including the insurance and employment contexts. *Id.*

Since *Pilot Life*, lower courts have repeatedly recognized that state common law and statutory bad faith and negligence claims against insurers are not saved from preemption under ERISA as such laws are not specifically directed to the insurance industry. *See, e.g., Cannon v. Group Health Service of Okla., Inc.*, 77 F.3d 1270, 1275 (10th Cir.), *cert. denied*, 519 U.S. 816 (1996) (state law negligence claim does not specifically regulate insurance company within the meaning of ERISA's savings clause); *Hogan v. Kraft Foods*, 969 F.2d 142, 144-45 (5th Cir. 1992) (state law claims for negligence and breach of duty of good faith and fair dealing do not specifically regulate insurance, banking, or securities and are thus not protected under ERISA's savings clause); *Bast v. Prudential Ins. Co. of America*, 150 F.3d 1003, 1008 (9th Cir. 1998), *cert. denied*, 528 U.S. 870 (1999) (breach of good faith claim brought under the Washington Insurance Code is not exempt under ERISA's savings clause); *Powell v. Chesapeake & Potomac Tel. Co. of Va.*, 780 F.2d 419, 423-24 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) (Virginia's implied covenant of good faith and fair dealing does not bear upon the "business of insurance" within

contemplation of ERISA's savings clause and thus is not saved from preemption).; *Gilbert v. Alta Health & Life Ins. Co.*, 276 F.3d 1292, 1296-98 (11th Cir. 2001) (Alabama statute governing insurer bad faith refusal to pay preempted under ERISA as statute had its roots in general principles of tort and contract law.); *Walker v. Southern Co. Serv., Inc.*, 279 F.3d 1289, 1292-94 (11th Cir.), *cert. denied*, 123 S. Ct. 111 (2002); *see also Kelley v. Sears Roebuck & Co.*, 882 F.2d 453, 456 (10th Cir. 1989); *Caffey v. UNUM Life Ins. Co.*, 302 F.3d 576, 582 (6th Cir. 2002); *Howard v. Coventry Health Care of Iowa, Inc.*, 293 F.3d 442, 446-47 (8th Cir. 2002); *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 270 (3d Cir. 2001). Mrs. Williams has not presented any authority supporting a different result under Georgia common law. Whether characterized as bad faith, breach of implied duty of good faith or negligence, Mrs. Williams' claim derives from Georgia's common law and, thus, cannot be saved from ERISA preemption.

c. Mrs. Williams' negligence claim does not substantially affect the risk pooling arrangement between the insured and insurer.

Mrs. Williams' negligence claim is not saved from preemption because it does not substantially affect the risk pooling arrangement between the insured and insurer. Indeed, the state law claim does nothing to allocate or affect the risk between the insured and insurer.

Several circuits have recognized that bad faith and negligence claims do not have the effect of transferring or spreading policyholder risk. *See Gilbert*, 276 F.3d at 1298-99; *Walker*, 279 F.3d at 1293; *compare Kelley v. Sears, Roebuck Co.*, 882 F.2d 453, 456 (10th Cir. 1989) (Colorado's

common law of bad faith neither spreads policyholder risk nor controls the substantive terms of the insurance contract); *Howard*, 293 F.3d at 447, ("[t]he law of bad faith does not effect a spreading of policyholder risk or define the terms of the relationship between the insurer and the insured."). This conclusion is directly supported by this Court's analysis in *Pilot Life*, where the Court ruled that Mississippi's bad faith law did not operate to spread policyholder risks. *Pilot Life*, 481 U.S. at 50, 107 S. Ct. at 1554. Because possible state law bad faith liability does not transfer or spread policyholder risk, such state law can not be found to substantially affect the risk pooling arrangement between the insured and the insurer.

Moreover, in *Smith v. Jefferson Pilot Life Ins. Co.*, 14 F.3d 562 (11th Cir.), *cert. denied*, 513 U.S. 808 (1994), the Eleventh Circuit held that a Georgia statute governing notice of termination of coverage to an insured was preempted under ERISA. In that ruling, the court recognized that such an obligation (not dissimilar to the purported notice obligation Mrs. Williams seeks to impose on Benicorp) did not have the effect of transferring or spreading policyholder risk. *Id.* at 569. As such, a purported common law notice obligation could not be found to substantially affect the risk pooling arrangement.

Since the ruling in *Kentucky Association*, other courts have found that bad faith and negligence claims do not substantially affect the risk pooling arrangement. *See Kidneigh v. UNUM Life Ins. Co of America*, 345 F.3d 1182, 1187-88 (10th Cir. 2003); *Ercole v. Conectiv and Coventry Health Care of Delaware, Inc.*, No. Civ. A. 03-186 GMS, 2003 WL 21104926 (D. De. May 15, 2003); and *McGuigan v. Reliance Standard Life Ins. Co.*, 256 F. Supp.

2d 345, 348 (E.D. Pa. 2003) (E.D. Pa. April 9, 2003). In *Ercole*, the court stated that:

> There can be little dispute that the Delaware state bad faith cause of action does not substantially affect risk pooling between insurer and insured. Rather, it simply provides extra-contractual damages not permitted by ERISA.

2003 WL *6. Such common law claims, whether cast as bad faith, breach of implied duty or negligence merely seek to provide extra-contractual damages for an insurer's conduct in a benefit determination and do not substantially affect the risk pooling arrangement between the insurer and insured.

Mrs. Williams' state law claim, like those addressed in other circuits, does not substantially affect the risk pooling arrangement. The claim simply provides an insured a claim for extra-contractual damages. Therefore, Mrs. Williams' state law claim cannot satisfy the second prong of the *Kentucky Association* test and, as such, is not saved from ERISA preemption.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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APPENDIX — AFFIRMATION OF JULIA SUMMERS IN SUPPORT OF BENICORP INSURANCE COMPANY'S BRIEF IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT DATED OCTOBER 15, 2002

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

Civil Action No. 5:01-CV-508-1

EDNA L. WILLIAMS,

Plaintiff,

v.

BENICORP INSURANCE COMPANY, BOSWORTH & ASSOCIATES, INC., and JOHN DOE and JOHN DOE CORPORATION,

Defendants.

AFFIRMATION OF JULIA SUMMERS IN SUPPORT OF BENICORP INSURANCE COMPANY'S BRIEF IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT

Julia Summers, submits this Affirmation in support of Defendant Benicorp Insurance Company's ("Benicorp") Brief in Support of Motion for Summary Judgment, and first being duly sworn upon her oath, states as follows:

1. I am over the age of 21 and am competent to testify to the matters asserted herein. I have personal knowledge of the facts set forth herein.

2. Benicorp is an insurance company licensed to transact business in twenty-eight (28) states (including the state of Georgia). Benicorp currently offers for sale group major medical indemnity insurance coverage to employer–sponsored groups in nine (9) states.

3. Since July 29, 1996, I have served as the Director of Compliance for Benicorp. Included within my responsibilities is to ensure that Benicorp is compliant with federal and state laws and to interpret and analyze the law to assist management and staff. As part of my responsibilities and duties, I am familiar with and frequently make use of Benicorp's business records, including those records attached to this Affirmation.

4. In connection with the indemnity insurance coverage, Benicorp has no arrangements in Georgia with any selected providers to furnish or deliver healthcare services. Benicorp has no contracts with healthcare providers in the state of Georgia. Benicorp does not select healthcare providers for its insureds in the state of Georgia. Benicorp does not have explicit standards (or even any standards) in Georgia for the selection of participating providers.

5. Benicorp is not and has never operated as a health maintenance organization. Benicorp does not act in any capacity as a "gatekeeper" whereby Benicorp could make determinations regarding an insured's access to a particular healthcare provider or a particular medical procedure or treatment.

6. Benicorp does not under maintain an exclusive provider arrangement in connection with its indemnity coverage issued in the state of Georgia.

7. Benicorp is not, and has never been, certified as a managed care entity as that term is defined at Georgia statute §33-20A-4. Benicorp is not, and never has been, subject to the reporting requirements for managed care entities contained at Georgia regulation 120-2-8-.05.

8. Benicorp sold and provided to Judd Publishing Company, Inc. ("Judd Publishing") indemnity coverage for medical and life insurance coverage for its employees, under Group No. 97244044 (the "Judd Publishing Plan"). A true and accurate copy of the Policy reflecting such coverage is attached hereto under **Tab A**. Under the Judd Publishing Plan, Judd Publishing employees and their dependants, including Mr. Williams, can receive medical services from any medical provider they desire without financial incentive or penalty. Indeed, employees and dependents of Judd Publishing under the Judd Publishing Plan could receive medical treatment and care from health care providers throughout the United States.

9. As part of the Judd Publishing Plan, Benicorp provided a certificate of insurance to James F. Williams, an employee of Judd Publishing, for coverage of life and medical insurance benefits. The written materials that were provided to Mr. Williams include the Certificate Book, a Summary of Coverage, and the Group Enrollment Form completed by Mr. Williams. A true and accurate copy of the Certificate

Book with Summary of Coverage and Group Enrollment Form provided to Mr. Williams is attached hereto under **Tab B**.

10. The Certificate Book, Summary of Coverage and Group Enrollment Form identify Mr. Williams as the beneficiary/insured, identify the medical and life insurance benefits available to Mr. Williams, and identify the procedures for obtaining the medical and life insurance benefits.

11. The Group Enrollment Form submitted by Mr. Williams shows that Mr. Williams agreed to be subject to all the terms of the Policy, and that any conflicts would be resolved solely by reference to the Policy. A separate copy of the Group Enrollment Form completed by Mr. Williams is attached hereto under **Tab C**.

12. The Employer Agreement & Application submitted by Judd Publishing to Benicorp shows that the intended source of financing for the Judd Publishing Plan is the employer's 50% premium contribution. A true and accurate copy of the Employer Agreement & Application is attached hereto under **Tab D**.

13. As indicated in the Employer Agreement & Application, Judd Publishing selected the type of coverage available to its employees and determined who would be eligible for group health insurance in its Plan. (*See* **Tab D**.)

14. At all pertinent times, Judd Publishing made all premium payments to Benicorp for the Judd Publishing Plan.

15. At no time was Benicorp the administrator of the Judd Publishing Plan. Benicorp did not create nor dictate the terms of the Summary Plan Description. Furthermore, Benicorp did not participate in the annual reporting with respect to the Judd Publishing Plan.

FURTHER AFFIANT SAITH NOT.

I DECLARE UNDER THE PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

Date: October 15, 2002

s/ Julia Summers
Julia Summers

EMPLOYER PARTICIPATION AGREEMENT

The Employer named below hereby appl[illegible] become a participant in the Benicorp Insurance Company Employee Benefits Trust (hereafter referred to as the "Trust"). In addition, the Employer also applies for Group Insurance benefits provided by the Policy [illegible]ed to the Trust and underwritten by Benicorp Insurance Company. The information provided by the Employer and his/her employees will determine eligibility for coverage under the Trust.

GENERAL EMPLOYER INFORMATION

Name of Company: JUDD PUBLISHING COMPANY, INC.

Street Address: 4853 EISENHOWER PKWY

P.O. Box No: ——— Phone: 912 - 474 - 3900

City/State: MACON, GA Zip: 31206 County: BIBB

Name of President: EDWIN F. JUDD SR.

Name of Contact Person: JOYCE JUDD

Nature of Business: PUBLISHING & PRINTING

Total number of employees: 10

Number of full-time employees 10 Number of full-time employees enrolling for medical coverage 9

What is the employer contribution? Employee 50 % _____ Dependent ~~0~~ % _____

REQUESTED EMPLOYER EFFECTIVE DATE: 9 / 1 / 97

The applicant has deposited $ 214231 for the requested coverage illustrated in Benicorp proposal # _____. This deposit is not an insurance premium. If Benicorp Insurance Company (Company) approves this application, it shall determine the exact amount of premium due. If approved, the Applicant agrees to pay any excess of the premium due over the deposit after notice of final approval. **No coverage is in force until written notice of approval is received from the Underwriting Department of the Company. Any proposed insured who is disabled on the group's effective date will not have coverage until they have complied with the Deferred Effective Date Provision of the Policy.**

NOTE: This application must predate the requested employer effective date and be received, with a check for the first month's premium, by the Company prior to the requested effective date.

REQUESTED EMPLOYEE EFFECTIVE DATE

The effective date for employees and dependents already covered by a group medical plan and not currently disabled will be the same as the Employer effective date. New entrants can make application for coverage following completion of the waiting period.

*Some industries require longer waiting periods. Please inquire as to the appropriate waiting period for your group.

The waiting period (period of continuous employment) before employees can make application for coverage is:

☐ 30 days ☐ 60 days ☒ 90 days ☐ 180 days

ENROLLMENT CERTIFICATION:

If the employee contributes toward the cost of medical coverage, the following participation must be met and MAINTAINED:

- Firms with 3 through 5 eligible employees must maintain 100% participation of all eligible employees.
- Firms with 6 through 9 eligible employees must maintain 100% participation of all elibible employees minus one.
- Firms with 10 through 49 eligible employees must maintain 75% participation of all eligible employees.
- Eligible is defined as "those employees who meet all the Eligibility Requirements (including working at least 30 hours per week on a monthly basis), and are not covered under another group insurance plan."

When the Employer pays all of the employee's premium, 100% of employees not covered under an HMO or governmental medical plan must participate for medical care. This rule also applies to dependents when the employer pays all of the dependents' premium.

In any event, participation requirements are not met if 40% or more of the full-time employees waive medical coverage for any reason.

NOTE: Groups who fail to maintain the participation requirements will automatically be terminated.

Maximum percentage of employees age 50 or older enrolling for medical coverage cannot exceed 50%.

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